Consent for Release/Exchange of Student Records and Information

Student's Name: _____ Date of Birth: ____/_____/_____

I hereby give permission to release/exchange/disclose the following:

☐ **All School Student Records**, including, but not limited to: personally identifying information; cumulative-permanent record; special education records; academic transcript; discipline records; health records; attendance records; and test scores.

Only Specific School Records:

☐ Personally Identifying Information
☐ Special Education Record (e.g. IEP, Evaluations, 504 Plans)
☐ Cumulative/Permanent Record
☐ Health Records
☐ Disciplinary Records
☐ Progress Monitoring Data
☐ Attendance Records
☐ Test Scores
☐ Other (Specify): _____

Health/Medical Information:

☐ Any and all records in the possession of _____ including mental health, HIV and/or substance abuse records
☐ Records regarding treatment for the following condition or injury _____
☐ Records covering the period of time between _____ and _____
☐ Other: _____

This information is to be released/exchanged between:

Agency(ies)/School(s): _____
Address: _____
Attn: _____

AND

Chicago Public Schools, District #299
School/Department:_____
Attn:_____

Purpose: This information is to be disclosed upon request and will be used for the following purpose(s):

☐ Educational evaluation and program planning
☐ Medical evaluation and treatment
☐ Health assessment and planning
☐ Referral to a separate day school/residential facility+
☐ Independent Educational Evaluation
☐ Other: _____

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 et seq.), and the *Illinois Mental Health and Developmental Disability Confidentiality Act* (740 ILCS 110/1 et seq.). I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent to the local school district representative. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district may not be protected by HIPAA Privacy Rules, but will become educational records protected by the *Family Educational Rights and Privacy Act* (20 U.S.C. Section 1232g). I understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I understand that I have the right to inspect and copy educational records and to challenge their contents. +I acknowledge that limiting the release/exchange or disclosure of records to one separate day school/residential facility may impact the District's ability to timely place the Student in a non-public facility.

This authorization is valid for one (1) calendar year from the date of signed consent indicated below.

_____
Parent Signature Date

_____
Witness Signature Date

_____
Student Signature* Date

*Student signature required for mental health records if Student is 12 years of age or older